Weill Cornell Imaging at NewYork-Presbyterian Mammography History Sheet

Patient

Patient ID _____ Site ID NYH Date of Birth _____

Last _____ First _____ Middle _____

Correspondence Language English (United States)

Demographics

Address _____

City _____ State _____

Zip _____ Country _____

Phone _____ Ext _____ Type ____ Phone _____ Ext _____ Type ____

E-mail Address _____

Referred By

Referring Clinician _____

Patient Physical Details

Sex at Birth _____ Gender _____

Height _____ Weight _____

Ethnicity _____

Current Complaints/Symptoms

_____

_____

☐ This is my first mammogram **When was the last time a physician examined your breasts** (MM/DD/YY) _____

Time Since Last Mammogram: _____ Last Menstrual Period (MM/DD/YY) _____ Could you possibly be pregnant? ☐ Yes ☐ No

Breast Surgical and Treatment History

Include date, type, and result(ex. Implants, Mastectomy, Lumpectomy, Biopsies, Radiation, etc.)

History of Cancer

Have you previously had any of the following cancers?

Cancer Type	at Age	Cancer Type	at Age	Cancer Type	at Age
☐ Breast	_____	☐ Ovarian	_____	☐ Other	_____

Gynecological History

☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal

First menstrual period at age: _____ Hysterectomy at Age: _____

First Full-term Pregnancy at Age: _____ Left Ovary was Removed at Age: _____

Number of Live Births: _____ Right Ovary was Removed at Age: _____

Menopause at Age: _____ Are you breast feeding? ☐ Yes ☐ No

Risk Factors

Have you been tested for any of the following cancer genes?

Outcome

☐ BRCA1 _____

☐ BRCA2 _____

☐ Ashkenazi Jewish

☐ No Known Previous Breast Biopsies

☐ No Known Family History of Cancer

☐ Previous Chest Radiation Therapy at Age: _____

☐ Previous Chemotherapy at Age: _____

Hormone History

Have you ever used or are you currently using any of the following hormones?

Currently Using	Age at First Use	Age at Last Use	Duration Years	Duration Months	Intended Duration
☐ Hormonal Contraceptives					
☐ Progesterone					
☐ Raloxifene					
☐ Estrogen					
☐ Tamoxifen					
☐ Unspecified					

Technologist: _____

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Please complete this page only if your family member(s) has(have) a history of breast or ovarian cancer.

Family History

Please list anyone in your family who has been diagnosed with cancer or been genetically tested for the cancer gene.

☐ New ☐ Existing Relative: ________ First Name: ________ ☐ Maternal ☐ Paternal If your relative is a niece or cousin please add their parent's name here: ________

Cancer Type ________ At Age ____ ☐ Unknown

Cancer Type ________ At Age ____ ☐ Unknown

Genetically Tested For: ______ Outcome: ______ Genetically Tested For: ______ Outcome: ______

☐ New ☐ Existing Relative: ________ First Name: ________ ☐ Maternal ☐ Paternal If your relative is a niece or cousin please add their parent's name here: ________

Cancer Type ________ At Age ____ ☐ Unknown

Cancer Type ________ At Age ____ ☐ Unknown

Genetically Tested For: ______ Outcome: ______ Genetically Tested For: ______ Outcome: ______

☐ New ☐ Existing Relative: ________ First Name: ________ ☐ Maternal ☐ Paternal If your relative is a niece or cousin please add their parent's name here: ________

Cancer Type ________ At Age ____ ☐ Unknown

Cancer Type ________ At Age ____ ☐ Unknown

Genetically Tested For: ______ Outcome: ______ Genetically Tested For: ______ Outcome: ______

Patient:

________________________ Please Sign Above   ____________ Date

The Patients' Bill of Rights is available for your review.